Laser's Role Limited in Spider Vein Treatment

BY MICHELE G. SULLIVAN

While advances in technology have made lasers more effective as a treatment for spider veins, sclerotherapy remains the standard for treatment, according to Dr. Margaret W. Mann.

While there have been significant advances in laser technology that make them an option for some spider veins, most telangiectases respond best to the more traditional treatment, said Dr. Mann, codirector of the dermatologic surgery and laser center at the University of California, Irvine.

"The majority of the time, I tend to reserve lasers for treating spider veins under a few circumstances," Dr. Mann said in an interview. They are best used for superficial vessels with a diameter of 1 mm or less, especially isolated telangiectases or those around the ankles. Patients with telangiectatic matting may also be candidates for laser treatment. Lasers might also be considered for a patient with needle phobia, or someone who has had a poor response to prior sclerotherapy, she said at a cosmetic dermatology seminar sponsored by Skin Disease Education Foundation (SDEF). "Outside of those circumstances, I tend to use sclerotherapy, which provides more reproducible results with less discomfort and fewer complications."

Different laser types have specific applications when treating spider veins. The potassium-titanyl-phosphate (KTP) and pulsed dye lasers are usually reserved for small vessels with a diameter of up to 1.5 mm. Melanin tends to absorb the energy from these lasers, which can result in hyperpigmentation.

"The majority of the time, I use the 1064-nm Nd:YAG, because it has a lower risk of pigmentary changes and because the advances in cooling devices associated with the Nd:YAG make overheating less likely," Dr. Mann said.

In contrast to telangiectases on the face, which are best treated with lasers, spider veins on the legs do not uniformly respond to lasers. The homogenous nature of facial telangiectases, both in diameter and depth, makes them easier targets than leg veins. "Telangiectases in the legs are a more heterogenous group; they tend to be different sizes and different depths, so it is harder to uniformly target them than it is the facial vessels."

Sclerotherapy 'provides more reproducible results with less discomfort and fewer complications.'

DR. MANN

She recommended an ultrasound evaluation for patients who may have more complicated vessel disease, including those with vessels larger than 5 mm in diameter, palpable varicosities, or classic corona phlebectasia—a clustering of spider veins along the medial malleolus.

Patients who have not responded to multiple sessions with sclerotherapy or lasers should undergo an ultrasound evaluation. "These are all indications of larger vessel disease, such as greater saphenous vein insufficiency." If the ultrasound confirms these findings, treatment with endovenous ablation or microphlebectomy should precede any further sclerotherapy or laser treatments.

Endovenous ablation can be performed in the office with tumescent anesthesia, she said. It requires only a small incision in which a laser fiber is threaded under ultrasound guidance within the vein. The laser is activated and withdrawn, which gently heats the lining of the vein and seals it shut.

Ambulatory microphlebectomy is also a safe, effective option for isolated varicosities. The procedure involves making multiple tiny incisions (1-3 mm) through which the varicose veins are removed. A compression dressing is necessary for 24 hours after the procedure, after which the patient can resume normal activity while wearing compression hose for 3 weeks.

Dr. Mann reported no financial conflicts regarding her presentation.

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